State of Wisconsin
EMPLOYEE REIMBURSEMENT REQUEST FORM

PLAN YEAR _____

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM PRIOR TO COMPLETION.
A MAILING ADDRESS AND FAX NUMBER ARE PROVIDED ON THE BACK OF THIS FORM.
PLEASE STAPLE SUPPORTING DOCUMENTATION TO THE BACK OF THIS FORM.

A. NAME _____ HOME PHONE ( ) _____ DAY PHONE ( ) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NO. _____ EMPLOYER _____

B. MEDICAL EXPENSE REIMBURSEMENT ACCOUNT

SUMMARY OF EXPENSES			DATES OF SERVICE PROVIDED		
Name of person receiving services	Relationship to Employee	Provider of services* (Ex: Hospital, Doctor/Dentist, Drugstore, Medical Supply Store)	From Mo/Day/Yr	To Mo/Day/Yr	Amount to be reimbursed
				TOTAL	

C. DEPENDENT CARE REIMBURSEMENT ACCOUNT

SUMMARY OF EXPENSES				DATES OF SERVICE PROVIDED		
Name of person receiving services	Relationship to Employee	Age and Grade	Name and address of person providing Dependent Care Services	From Mo/Day/Yr	To Mo/Day/Yr	Amount to be Reimbursed
					TOTAL	

SIGNATURE OF DAY CARE PROVIDER LISTED ABOVE _____

Separate receipts are not required if your dependent care provider signs this form after you have completed and signed it.

I understand, agree and certify to the following:

- I will use my reimbursement account(s) only for IRS-qualified expenses that are permitted under my employer's Employee Reimbursement Account plan. The expenses listed above were provided to me and my IRS-eligible dependents on the date(s) indicated above and were incurred within my period of coverage during the plan year.
- The information I have provided above is a true and accurate statement of unreimbursed medical or dependent care expenses provided to me and/or my eligible dependent on the date(s) indicated.
- I will request reimbursement only after the services have been provided.
- I have not and will not seek reimbursement through any other source, and will exhaust all the other sources of reimbursement, including those provided under my Employer's plan(s), before seeking reimbursement from my ERA.
- I will collect and maintain sufficient documentation to validate my reimbursed ERA expenses.
- I will not claim any reimbursed ERA expense for any federal income tax deduction or credit.
- I specifically release my Employer and FBMC from any liability resulting from either my participation in the Employee Reimbursement Account (ERA) program or for any misrepresentation I make regarding my requests for reimbursement.
- The dependent care expenses I submit for reimbursement were incurred to allow me and my spouse (if married) to work or actively look for work. My spouse is considered working (i.e., gainfully employed) if he or she is a full-time student for five months during the calendar year at an educational organization, or is physically or mentally incapable of self-care.
- **I have read and understand the information on the front and back of this form and in the Wisconsin Employee Reimbursement Account Program booklet.**

PARTICIPANT'S SIGNATURE: _____ **DATE:** _____

FOR OFFICE USE ONLY	DATE	AUTHORIZATION #	INITIAL

FBMC/WISC/1203

INSTRUCTIONS FOR REIMBURSEMENT

To assure the quickest turnaround and best service, please read these instructions carefully. Incomplete or improperly completed Reimbursement Requests will be returned unprocessed.

Requesting Medical Expense Reimbursement:

- Complete Sections A & B of the Reimbursement Request Form. Be sure to sign and date the form.
- Attach a legible copy of a receipt, invoice or bill showing the name of the provider, the date service(s) were received, the cost of the service(s), the type of service(s) incurred, and the name of the person(s) for whom the service(s) were provided. The complete name of all drugs must be included on receipts for both prescription and over-the-counter drugs. Cancelled checks and charge receipts are not accepted as proof of service.
- Attach an Explanation of Benefits (EOB) if the expense is covered by an insurance plan. The EOB must show the date service(s) were received, the type of medically necessary service(s) received, the name of the person(s) for whom the service(s) were provided, the cost of the service(s), and the uninsured portion of the cost.
- Some medical treatments, drugs and services that could be deemed cosmetic or not medically necessary require a Letter of Medical Need from the treating healthcare provider.
- Reimbursement for certain capital expenditures* may require (i) a Letter of Medical Need from the treating healthcare provider, (ii) a personal use letter signed by the patient, and (iii) a capital expense appraisal letter.
  - * Some capital expenditures may qualify as medical care under IRC § 213. General rules for capital expenditures that could be reimbursable are: (i) a special version of an otherwise personal item can be reimbursed to the extent of the increased cost; (ii) an item permanently attached to a dwelling can only be reimbursed to the extent that its cost exceeds the increase in value; (iii) if there is no personal element and the item is not attached to a dwelling, it must only be used by the person for whom the medical need has been determined; but (iv) if the item is used by others as well, only a prorated amount of the entire cost can be reimbursed.
- The IRS standard mileage reimbursement rate for use of an automobile to obtain medical care is subject to change annually. Any claims submitted for mileage may be adjusted to this annual standard rate.

Requesting Dependent Care Reimbursement

- Complete Sections A & C of the Reimbursement Request Form. Be sure to sign and date the form.
- Attach a legible copy of a receipt, invoice, or bill from the provider showing the name, address, and tax I.D. Number (or Social Security Number) of the provider, the beginning and ending dates of the provided services, the cost of the service(s), and the age, grade, and name of the IRS-eligible person(s) for whom the service(s) were provided. A signed receipt is required if your provider is an individual. In lieu of a separate receipt, your day care provider may sign this form. Cancelled checks and charge receipts are not accepted as proof of service.
- Payments for dependent care cannot be made to you, your spouse, or someone you or your spouse claim as a tax dependent.
- Educational expenses incurred for a child in kindergarten and up are not reimbursable. Expenses such as tuition, registration fees, activity fees, books, supplies and meals are not reimbursable. The cost of dependent care before and after school is reimbursable.
- A qualified person is your tax dependent age 12 or younger, or your spouse or tax dependent who is physically or mentally incapable of self-care. The individual must reside in your household at least eight hours a day.
- Approved reimbursement requests will be paid after the last date of service for which you are requesting reimbursement.
- Dependent care reimbursement requests will be paid to the limit of the amount currently in your account. Any balance due will be automatically paid as more money is credited to your account.
- You must file an IRS Form 2441 (when filing taxes using Form 1040) or Schedule 2 (when using Form 1040A) with your personal Federal income tax return which requires you to provide the name and tax identification number (or Social Security number) of your dependent care provider.

General Reimbursement Information

- Reimbursement for both medical and dependent care expenses can be requested on the same form.
- Expenses may be submitted for reimbursement only after the service has been provided, regardless of when you paid for the service.
- The deadline for submitting reimbursement requests is March 31 for expenses incurred in the prior plan year.
- Unused funds that remain in your account after the end of a plan year cannot be returned to you nor carried forward to the next plan year but will be forfeited to the State.
- Medical or dependent care expenses that are reimbursed through the ERA program cannot also be claimed for any income tax deduction or credit.
- You must exhaust all other sources of reimbursement for eligible medical and/or dependent care expenses before seeking reimbursement from your Employee Reimbursement Account.
- If dates of provided services begin in one plan year and end in the next plan year, you must submit a separate Reimbursement Request for each plan year in which the services were provided.

MAIL ONLY THE *WHITE* COPY:

Fringe Benefits Management Company (FBMC)
Post Office Box 1800
Tallahassee, FL 32302-1800

FAX: (850) 425-4608

Do not mail the copy of your faxed transmittal to FBMC.

Be sure your form is signed and dated and that the required supporting documentation is attached.
Keep a copy for your records.

FBMC CUSTOMER SERVICE: (800) 342-8017 or webcustomerservice@fbmc-benefits.com

FBMC WEB SITE ADDRESS: http://www.fbmc-benefits.com

FBMC INTERACTIVE BENEFITS INFORMATION LINE: (800) 865-3262

DEPARTMENT OF EMPLOYEE TRUST FUNDS INTERNET: http://etf.wi.gov